Attachment 2.1 - B

A Managed Care Organization (MCO) is defined by state law as 1) a state certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments or 2) a corporation that a) is a managed care system authorized to receive medical assistance prepaid capitation payments, b) enrolls only Medicaid program recipients, and c) operates within certain financial rules as discussed below.

MCOs are responsible for delivering specific health services under Maryland Medicaid's HealthChoice Program which operates under a federally approved 1115 waiver.

- Organization's Primary Purpose -

A Managed Care Organization under Maryland Medicaid's HealthChoice Program is an organization which has undergone an application review and demonstrated the professional and financial ability to provide specific health services (as defined in Health-General Article, Title 15, Subtitle 103, Annotated Code of Maryland) to an enrolled group of persons consistent with the applicable Federal and State laws and has contracted with this Department to deliver services to enrolled Medical Assistance Program recipients (COMAR 10.09.62 through 10.09.73)

The specific health care services for which MCOs are responsible consist of all services available to MA recipients as of January 1, 1996 with the exception of skilled nursing facility, intermediate care facility, chronic hospital, mental hospital, and other services specifically excluded by regulations COMAR 10.09.65

- Accessibility to Services -

"Local Access Area" means the local geographic area, as identified by the zip code groupings in COMAR 10.09.66.06E, that is located within the relevant MCO's service area and in which the relevant enrollee resides.

"Service Area" means a geographical area comprised of one or more of Maryland's counties, with each selected county included in its entirety.

- Risk of Insolvency -

Each managed care organization shall be actuarially sound. Except as otherwise provided in this section, the surplus that a managed care organization is required to have shall be paid in full. A managed care organization shall have an initial surplus that exceeds the liabilities of the managed care organization by at least $1,500,000. In consultation with the secretary (of the Department), the insurance commissioner may adjust the initial surplus requirement for a managed care organization that is not licensed as a health maintenance organization.

An managed care organization shall have initial surplus that exceeds liabilities by at least $1,250,000. if a managed care organization has initial surplus that is at least $1,250,000 but less than $1,500,000, prior to approval, the department shall designate funds under paragraph (1)(ii) of this subsection sufficient to provide an initial surplus of at least $1,500,000

Each managed care organizations shall maintain a surplus that exceeds the liabilities of the managed care organization in the amount that is at least equal to the greater of $750,000 or 5 percent of the subscription charges earned during the prior calendar year as recorded in the annual report filed by the managed care organization with the commissioner.

No managed care organization shall be required to maintain a surplus in excess of a value of $3,000,000. For the protection of the managed care organization's enrollees and creditors, the applicant shall deposit and maintain in trust with the state treasurer $100,000 in cash or government securities.